United Nations, 2007. *United Nations Declaration on the Rights of Indigenous Peoples*. New York: United Nations.

Waldram, J., Herring, D. and Young, T., 2006. *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*, 2nd ed. Toronto: University of Toronto Press.

Walters, K.L., Beltran, R., Huh, D. and Evans-Campbell, T., 2011. Dis-placement and dis-ease: Land, place, and health among American Indians and Alaska natives. In: L.M. Burton, S.P. Kemp, M. Leung, S.A. Matthews and D.T. Takeuchi, eds. *Communities, neighborhoods, and health*. New York: Springer. pp. 163–99.

Waziyatawin, 2009. *You can't un-ring a bell: Demonstrating contrition through action*. Ottawa: Aboriginal Healing Foundation. pp. 137–44.

Wesley-Esquimaux, C., 2007. The intergenerational transmission of historic trauma and grief. *Indigenous Affairs*, 4(6), pp. 6–11.

Wilson, K., 2003. Therapeutic landscapes and First Nations peoples: An exploration of culture, health, and place. *Health & Place*, 9(2), pp. 83–93.

Wilson, S., 2008. *Research is ceremony: Indigenous research methods*. Halifax: Fernwood Publishing.

World Health Organization. 2012. *Frequently asked questions*. Available online at www.who.int/suggestions/faq/en/index.html (accessed January 30, 2016).

Wylie, J., 2012. *Suicide prevention and Two-Spirited people*. Ottawa: National Aboriginal Health Organization.

4 Exploring the Intersections Between Violence, Place, and Mental Health in the Lives of Trans and Gender Nonconforming People in Canada

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Transgender and gender nonconforming (T/GNC) people represent some of the most creative, resilient, courageous, diverse, and beautiful people in Canada. They also represent one of the most marginalized groups in our society, and experience a variety of intersecting health inequities (Bauer et al., 2009). Although there is very limited Canadian-specific research, existing North American studies reveal that T/GNC people are more vulnerable to violence across their life span than the general population, experiencing multiple and pervasive forms of violence in various public and private places (White and Goldberg, 2006; Stotzer, 2009, 2014; Grant et al. 2011; Scheim et al., 2014). It also has been noted that gender surveillance, harassment, and violence may occur and be experienced differently by different T/GNC people, and in some places more than others (Namaste, 2000; Stotzer, 2014). As such, geography can provide a valuable lens for gaining a better understanding of violence, mental health, and emotional well-being within the lives of T/GNC individuals, particularly as different spaces and places can shape experiences of belonging, safety, exclusion, harassment, and violence.

Numerous mental health conditions have been associated with experiencing violence for all survivors (not only T/GNC people), including post-traumatic stress disorder, anxiety, depression, and suicide. Recent studies show extremely high rates of depression and suicide for T/GNC people who have experienced social injustice, including anti-trans stigma, harassment, as well as physical and sexual assault (Scanlon et al., 2010; Grant et al., 2011; Rotondi et al., 2011a, 2011b; Bauer et al., 2013). Furthermore, T/GNC individuals experience multiple barriers to accessing health care (Bauer et al., 2009; Heinz and MacFarlane, 2013) and violence intervention support (Namaste, 2000; White and Goldberg, 2006; National Coalition of Anti-Violence Programs, 2014). T/GNC people who are Indigenous, of color, sex workers, and/or living in poverty face some of the highest levels of discrimination and violence due to a combination of racism, poverty, and anti-transgender and/or sex worker stigma, discrimination, and injustice (Grant et al., 2011; Longman Marcellin et al., 2013a, 2013b; Scheim et al., 2013; World Health Organization et al., 2013).

In this chapter I provide an overview of some themes emerging in the literature about violence, place, and mental health in the lives of T/GNC people.

I bring together literature from geography, trans studies, social work, psychology, and health studies while identifying the benefit of an intersectional and interdisciplinary approach to understanding health equity issues in the lives of T/GNC people in Canada (for an introduction to intersectionality in health research, see Chapter 2). While there are many urgent health equity issues facing T/GNC youth, this chapter focuses on literature about the experiences of adults. Given the dominant social and cultural context that perpetuates harmful stereotypes about T/GNC people and privileges cisgender (non-trans) identities and expressions, I begin this chapter by discussing some key concepts and terms.

Understanding the Terminology

A person's identity is made up of many parts, including their gender identity, gender expression, biological sex, and sexual orientation. However, it is commonly believed that humans are either male or female, and that gender and sex are the same and unchangeable (For Ourselves: Reworking Gender Expression [FORGE], 2012a). These are harmful misconceptions, as gender is a spectrum and not determined by biology (chromosomes) and anatomy (genitals) (FORGE, 2012a).

Gender identity can be understood as a person's deeply felt sense of themselves as male, female, both, neither, something in-between, or beyond (FORGE, 2012a). As such, a person's sex can be different from their gender identity. Transgender, or trans, is an umbrella term that describes a wide range of diverse people whose gender identity and/or gender expression differs from what they were assigned at birth. It may include those who identify as transsexual, "Two-Spirit," bigender, genderqueer, cross-dressers, gender variant, gender fluid, or simply man or woman (Grant et al., 2011). Sometimes, an asterisk is included (trans*) to actively include non-binary and/or non-static gender identities such as genderqueer (National Film Board of Canada, 2014). (As mentioned in Chapter 3, the term "Two-Spirit" is used by some Indigenous people to describe the diverse roles and identities of lesbian, gay, bisexual, trans, queer, and/or gender-diverse Indigenous people in North America.) "Gender nonconforming" refers to individuals who express their gender in ways that differ from societal expectations and/or stereotypes related to gender (Grant et al., 2011). Some gender nonconforming people identify with the broad umbrella category of "trans," while others do not.

"LGBTQ2S" is another umbrella category to represent lesbian, gay, bisexual, transgender, queer and Two-Spirit people of diverse sexual orientations and gender identities. Although commonly used, this umbrella term can have a homogenizing effect, blurring the differences between gender identity and sexual orientation.

Importantly, these terms and definitions do not include all of the many identities or lived experiences of T/GNC people. For example, some trans people choose to transition medically by taking hormones and/or having surgery, while others do not. Some choose to socially and legally transition by changing their name, clothing, hairstyle, mannerisms, and/or social roles, while others do not (National Film Board of Canada, 2014). In other words, identifying as trans, transgender, or other terms within this umbrella category does not depend on criteria such as surgery or hormone treatment status, but can be decided upon only by individuals themselves (National Film Board of Canada, 2014).

Transphobia is an "irrational fear of, aversion to, or discrimination against people whose gendered identities, appearances, or behaviors deviate from societal norms" (Serano, 2007, p. 12), and is produced through multiple forms of social exclusion and violence. It exists within a context of cisnormativity, which refers to the expectation that all people are – and should be – cisgender, and the belief that transgender identities or bodies are less "authentic" or "normal" than cisgender identities and bodies (Bauer et al., 2009). Cisgender refers to someone who identifies with the gender they were assigned at birth, and is the term used to acknowledge the societal privilege of those people who are not T/GNC (National Film Board of Canada, 2014). Considering this, transphobia and cisnormativity can be understood as social determinants of health. (These specific social determinants were not outlined in Chapter 2 when this approach was introduced. However, they are highly relevant and influential in shaping the lives of T/GNC people.)

What We Know About Canadian Trans People

Our knowledge about the social demographics of T/GNC people in Canada is very limited. Much of the data we rely on in our research, education, and service delivery with T/GNC people are based on communities in the USA (Bauer et al., 2012; Heinz and MacFarlane, 2013). However, some recent research in Canada does provide a glimpse of who trans people are in different regions of the country. The Trans PULSE Project – a community-based research project investigating the impact of social exclusion and discrimination on the health of trans people in Ontario, Canada – conducted a survey of 433 trans people aged 16 or over in Ontario. This project revealed that while most trans people had either a male/masculine or female/feminine identity, about one in five identified in some way as both, neither, or gender fluid (Coleman et al., 2011), and that the "participants identified across a broad range of sexual orientation identities" (Bauer et al., 2010, p. 1). This survey also found that geographically, trans people live in communities across the province, and "despite the fact that the majority of trans services are located in Metropolitan Toronto, 68 percent of trans Ontarians live outside that postal code area" (2010, p. 2). The majority of respondents (88 percent) identified as white Canadian, American or European, while 7 percent identified as First Nations, Métis and Inuit, and 22 percent indicated a range of other ethnoracial identities including East Asian, South Asian, Southeast Asian, black Canadian, black American, black African, Latin American, Middle Eastern and "other" (Longman Marcellin et al., 2013b; Scheim et al., 2013).

In a recent community needs assessment with 54 trans respondents on Vancouver Island, British Columbia, 43 percent identified as female-to-male (FTM), 39 percent identified as male-to-female (MTF), while 18 percent described their gender identity as either transgender, bigender, mixed gender, or genderqueer, and did not select a gender-specific referent (Heinz and MacFarlane, 2013, p. 4). Most respondents lived in the Greater Victoria area (68 percent), while others were located throughout the island including remote rural locations, as well as neighboring islands. In terms of ethnicity, 67 percent were of British descent, 47 percent of other European descent, 13 percent of Aboriginal descent, and 9 percent of East Asian or South Asian descent (2013, p. 4).

This brief description of survey results is not meant to provide comprehensive or representative sociodemographic statistics about the diverse identities of T/GNC people in Canada, but rather to share some of the recent data collected by trans-Canadian community research projects seeking to learn more about the sociodemographics and lived experiences of T/GNC people in Canada.

Setting the Context

It is important to place this research topic within the past and present context of the regulatory power of psychiatric discourses. As Canadian scholars Nick Mulé, Andrea Daley, and the Rainbow Health Network state, "the continued classification of diverse sexual and gender identities and expressions as clinical disorders constitutes the ongoing surveillance, pathologizing and regulating of otherwise variant expressions of sexuality and gender" (2010, p. 11; see also Daley and Mulé, 2014).

Transgender identities first appeared in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association in 1980, and were categorized as "gender identity disorder" until the most recent revision (DSM-5), which replaced "Gender Identity Disorder" with the term "Gender Dysphoria" – with the stated intention to avoid stigma for people whose gender at birth is contrary to the one with which they identify (American Psychiatric Association, 2013). The dominant discourse surrounding the DSM suggests that it provides mental health clinicians with a common language, or "diagnostic criteria," for accurate and consistent diagnosis of mental health "disorders." However, many reject the DSM's pathology and contest its legitimacy, arguing it is a power-laden classification system that institutionalizes arbitrary constructions of normalcy or abnormalcy, and reflects the interests and assumptions of dominant social groups. In this way, the DSM reproduces hegemonic notions of gender, race, ethnicity, class, (dis)ability, and sexuality (Cermele et al., 2001; LeFrancoise et al., 2013), ultimately contributing to stigma towards diverse gender expressions and trans identities.

Erasure

Unfortunately, a legacy of negative academic research conducted on T/GNC people also exists, as well as the erasure of trans people from knowledge production (Namaste, 2000). Montreal-based activist scholar Viviane K. Namaste (2000) first proposed the framework of erasure to describe "the conceptual and institutional relations through which transsexual and transgender people disappear from view" (p. 137). She defines erasure as the "defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible" (pp. 4–5). Namaste's work has been critically important for theorizing and documenting the way trans people are made invisible through discourse and institutionalized practices, and excluded from social service and health care agencies, and anti-violence organizing.

Researchers from the Trans PULSE Project argue that transphobia is an insufficient explanatory framework for understanding the processes that exclude trans people from accessible and appropriate health services (Bauer et al., 2009). Informed by Namaste's work, they state that

> while transphobia may be a useful concept in understanding the motivations underlying the actions of individuals, its use as an explanation has obscured the more systematic nature of trans marginalization by isolating the particular problem to acts rather than embedding the problem in broader cultural and political contexts. (Bauer et al., 2009, p. 350)

Based on qualitative data from focus groups with 85 trans community members, Bauer and colleagues' (2009) health research documented how the systemic erasure of trans people occurs in many ways, both through informational and institutional contexts. They identified two key sites of erasure in health care contexts (which can be applied to other contexts as well):

1) informational erasure – which is evident in the lack of knowledge, research, and knowledge synthesis about trans people's lives, and in the minimization of the importance of trans-related research; and
2) institutional erasure – which occurs through policies and practices that impose cisnormative gender binaries.

Bauer et al. (2009) also found that erasure could be both active and passive, with active erasure including visible discomfort by service providers, refusal of service, and violent responses with the intent to harm or intimidate. Passive erasure involves a lack of knowledge about trans people and their health needs, and the assumption that their lives and health needs are not relevant or important (Bauer et al., 2009). The main finding from this research is that trans people experience profound social exclusion in their daily lives (Bauer et al., 2009).

Kwakwaka'wakw activist and scholar Sarah Hunt (2015) draws on both Indigenous and decolonial theorizing about the disappearance of Indigenous people through settler colonialism, and Namaste's work on erasure, to address the way that colonial gender binaries function as key tools of settler colonialism. As she explains:

> At the heart of the colonization of Turtle Island lies the settler colonial project of native disappearance, which is necessary for the development of a prosperous settler society. Colonial laws and ideologies have entailed the imposition of gendered and racialized categories, which have been used to ensure fewer and fewer natives over time. (105)

She notes that the "erasure and invisibility of those we now call Two-Spirit and transgender people was accomplished through … combined ideological, socio-legal and spatialized enforcements of colonial gender norms for 'Indians'" (106). Importantly, Hunt (2015) points out that some Indigenous self-determination frameworks and Indigenous women's organizations in Canada have also relied on these colonial gender categories, and as a result their frameworks and approaches often fail to account for Indigenous trans and Two-Spirit people's lives.

While T/GNC communities have been erased in knowledge production and generally understudied, research which *has* included trans people often has been conducted through processes that are stigmatizing and alienating, most being conducted in university or clinical settings without community input (Bauer et al., 2009). This is also combined with a history of research about trans people by cisgender researchers in Canada and around the globe that has been paternalistic, voyeuristic, pathologizing, and unethical – such as collecting data without consent, frequently neglecting to report research findings back to communities, and failing to disseminate the research in meaningful ways that are useful for trans communities (see the discussion in Bauer et al., 2009; Travers et al., 2013; Pyne, 2014). Similar harmful health research practices have been widely practiced on other marginalized communities, including Indigenous people (see Chapter 3), low-income and poor people (see Chapter 7), sex workers, and people of color. Consequently, this has produced skepticism and mistrust towards academic, cisgender researchers, as well as those who are white and middle class. Being aware of this context of erasure and harmful research practices with T/GNC people is important for understanding the lack of research about their lives, as well as the implications for current research in the area of mental health, violence, and place.

Violence in the Lives of T/GNC People

Research has shown that violence in the lives of T/GNC people across the globe takes many forms, including hate or bias-motivated violence, intimate

partner violence and/or domestic violence, and sexual assault (National Coalition of Anti-Violence Programs, 2014; Stotzer, 2014). These forms of violence often include transphobic elements, and may be combined with sexist, racist, economic or classist, ableist and homophobic tactics, including for example:

> [A]ssault, mutilation or denigration of body parts such as chest, genitals, and hair that signify specific cultural notions of gender … withdrawal of financial support for trans-specific care (e.g. electrolysis, hormones, surgeries) … ridicule of cross-gendered behaviour or appearance; [trans-specific] threats to limit or prohibit access to children or services … and threats to reveal the victim's gender identity to employers, financial aid workers, health care workers, immigration personnel, or anyone else with possible influence or control over the survivor's well being. (White and Goldberg, 2006, p. 126)

Many challenges exist in accurately determining the rates and scope of violence due to a lack of reliable data sources, underreporting, problematic tracking mechanisms, sampling research methodologies, inconsistent data analysis methods, the conflation of gender and sexual orientation, and diverse definitions of violence used among researchers and organizations (White and Goldberg, 2006; Goldberg and White, 2011; Ristock, 2011; FORGE, 2012b; Greenberg, 2012; Stotzer, 2014). For example, a lack of data due to underreporting is a result of many T/GNC individuals' fear of transphobic and racist responses from police, victim assistance programs, health care providers, and crisis counseling support services (White and Goldberg, 2006; Grant et al., 2011; FORGE, 2012a; National Coalition of Anti-Violence Programs, 2014; Stotzer, 2014). In addition, in a transphobic social context, many people are not out as trans, making it difficult to identify a large random sample and demonstrate a clear and accurate prevalence rate.

Regardless of difficulties in determining actual prevalence rates, it has been shown that violence in the lives of T/GNC individuals is pervasive, ongoing, and severe across the globe (Stotzer, 2014, p. 51). Stotzer (2014) notes that the first quantitative study of transphobic bias crimes across the European Union (see Turner et al., 2009) found that in a sample of more than 2,500 transgender people, 70 percent reported experiencing some type of verbal or physical violence because of their gender identity. More specifically, it is anti-trans or hate-motivated violence that is the most frequently recorded form of violence experienced by T/GNC people. For example, it has been found that reports from T/GNC people of hate violence in the USA have increased by 21 percent since 2012 (National Coalition of Anti-Violence Programs, 2014), while another US-based study on hate-motivated violence against T/GNC people found that 60 percent of all trans people had experienced it (Moran and Sharpe, 2004).

Research has documented various forms of hate-motivated violence against T/GNC individuals including:

- threats and harassment;
- hate speech (via letter, e-mail, telephone, or in person);
- vandalism;
- physical attacks;
- assault with a weapon;
- sexual violence; and
- murder.

Transphobic violence also intersects with other forms of systemic oppression and violence such as colonialism, racism, classism, ableism, and state and police violence. For example, studies in the USA (Stotzer, 2009) and Europe (Turner et al., 2009) suggest that trans women (MTF transgender individuals), as opposed to trans men (FTM individuals) may be more at risk of experiencing transphobic violence (White and Goldberg, 2006; National Coalition of Anti-Violence Programs, 2014; Stotzer, 2014). Although most studies of anti-LGBTQ2S violence have tended to overlook the intersectional nature of race, class, gender, ability, and sexuality in the experiences of victims or perpetrators of hate-motivated violence, some research suggests that trans women of color and trans Indigenous and Two-Spirit women are more at risk of violence than other LGBTQ people – with a large percentage of transgender murder victims internationally being trans women of color (White and Goldberg, 2006, p. 125; National Coalition of Anti-Violence Programs, 2014).

Violence against T/GNC individuals may be perpetrated by strangers, but more often it is perpetrated by those who are known to the victim, including co-workers, neighbors, employers, acquaintances, ex-lovers, community members, and even friends (White and Goldberg, 2006; Grant et al., 2011; Stotzer, 2014). The National Transgender Discrimination Survey (Grant et al., 2011) in the USA found that 50 percent of respondents had experienced sexual assault, with the majority being perpetrated by intimate partners, family members, and others known to the individual. These findings disrupt common understandings of trans-specific violence, as some "reports indicate that a significant number of trans survivors knew the perpetrator ... which challenges conventional understandings of hate crimes as 'public' and distinct from family and relationship violence" (White and Goldberg, 2006, p. 125; also see Stotzer, 2014). Research conducted through the Transgender Sexual Violence Project by FORGE (an American national education, advocacy, and support umbrella organization for trans people and significant others, family, friends, and allies), found that 29 percent of respondents had been sexually assaulted by an intimate partner (Munson and Cook-Daniels, 2015). Another US study conducted by The Survivor Project (a volunteer-run organization addressing the needs of intersex and trans survivors of domestic and sexual violence in Portland, Oregon), found that 50 percent of respondents had been raped or assaulted by an intimate partner; yet as commonly found among this population, only 62 percent (31 percent of the total sample) of those raped or assaulted actually identified as being survivors of domestic violence when asked directly (Courvant and Cook-Daniels, 1998, p. 2). Overall, there are very few empirical studies which have explicitly examined intimate partner violence or domestic violence in the lives of T/GNC people, and none of these have taken place in Canada (Courvant and Cook-Daniels, 1998; Brown, 2011; Grant et al., 2011; National Coalition of Anti-Violence Programs, 2014). Nicola Brown (2007, 2011) explores the experiences of trans people living in Canada and the USA who have been abused and/or abusive in their intimate relationships. She argues that the traditional gender-based heterosexual model is insufficient for understanding violence perpetrated by, or against, trans people in intimate relationships. She calls for community initiatives to raise awareness by discussing the complexities of power, privilege, marginalization, and dynamics of abuse.

Within Canada and beyond, very little research has examined intimate partner violence in the lives of Indigenous trans and Two-Spirit people. However, some Canadian literature has included general discussion of trans and Two-Spirit experiences of intimate partner violence or domestic violence (for example, see White and Goldberg, 2006; Brown, 2007, 2011; Ristock et al. 2010; Goldberg and White, 2011; Ristock, 2011; Taylor and Ristock, 2011). Catherine Taylor and Janice Ristock (2011) reviewed studies which have looked at intimate partner violence experienced by Indigenous LGBTQ and Two-Spirit people, showing that these studies have documented experiences of multiple forms of physical and sexual violence, historical trauma, and state violence. Research conducted by the Canadian Aboriginal Two-Spirit and LGBTQ Migration, Mobility, and Health Research Project revealed that 23 out of 25 participants in Vancouver, British Columbia indicated that they had experienced domestic violence, while 19 out of 24 participants in Winnipeg, Manitoba reported they had experienced some form of violence in a same-sex relationship (Ristock et al., 2010, 2011). As Taylor and Ristock (2011) describe, this context of violence is "linked to and supported by larger social structures that create and sustain inequalities and disadvantages" (p. 309), and as a result, anti-violence efforts must be allied with anti-colonial Indigenous strategies to oppose state violence.

Research conducted by trans people and their allies has addressed more often the intersections between multiple forms of interpersonal, hate-motivated, institutional, police, and state violence (Namaste, 2000; Goldberg and White, 2011). For example, Joshua Goldberg and Caroline White (2011) note that the history of trans anti-violence organizing in North America has been different from the dominant feminist anti-violence movement in a number of ways:

> Trans activism was led in large part by racialized working poor and working class sex trade workers and night club entertainers, many of whom identified as male-to-female (MTF). As a consequence, the ways that

> "violence" and "safety" were tackled by trans activists were not limited in the same ways as dominant feminism; police violence, prison violence, violence against sex trade workers and people living on the street, violence in the psychiatric system, deaths resulting from refusal of emergency services, and other manifestations of systemic as well as interpersonal class–race–gender violence were high priorities for many early transgender organizers in urban areas throughout North America. (2011, p. 57)

Although not widespread, some research has acknowledged the interconnections between racialization and anti-transgender stigma, and some scholars and activists have applied an intersectional approach, an Indigenous gender-based analysis and/or a decolonial approach (White and Goldberg, 2006; Taylor, 2009; Ristock et al., 2010, 2011; Goldberg and White, 2011; Grant et al., 2011; Taylor and Ristock, 2011; Longman Marcellin et al., 2013a; Scheim et al., 2013; Hunt, 2015). Such approaches not only hold the potential to shed much-needed light on the diverse experiences of violence among a diverse community of T/GNC individuals, but they also encourage us to critique hegemonic framings and expand our theorizing and politics to account for the interlocking nature of the different forms and spaces of violence.

Trans Health Geographies: The Significance of Place

Health geography "considers the significance for physical and mental health of *interactions between people and their environment*. It investigates why *space* and *place* are important for health variation in human populations" (Curtis, 2010, p. 3; emphasis in original). A health geographic perspective can provide a unique understanding regarding the ways that various social and spatial contexts, landscapes, and environments enhance or harm T/GNC people's emotional well-being or mental health. For example, it is important to understand and identify the places where T/GNC people experience transphobic discrimination, harassment, and violence, and the places they avoid to maintain their safety; as well as those places where they do experience a sense of belonging, well-being, and safety. Although a geographic perspective can be valuable in addressing social, health, and spatial inequities among T/GNC populations, no health geographic work exists per se in Canada or elsewhere that explicitly explores theorizing and/or the lived experiences of T/GNC people.

Although the focus on health is not explicit, some geographers have begun to explore the relationships between space, place, and T/GNC people. Namaste's (1996) article is one of the most important in the field of geography, which examines the issue of gender and regulation of public space. Drawing on Namaste's work, Kath Browne (2004) was one of the first queer geographers to examine the violent regulation of gender nonconformity in public spaces such as bathrooms. Catherine Nash (2010) and Petra Doan (2007, 2010) are two other geographers who have written about gender, trans people, and

place. In examining the regulation of public space, Doan (2010) has looked at how individuals who "transgress gender norms experience a tyranny of gender that shapes nearly every aspect of their public and private lives" (2010, p. 635). Cisgender looks of disapproval, whispers, and long stares work to create an environment of discomfort and make T/GNC people feel out of place in everyday spaces. As such, Doan calls for more geographers to "explore the parameters of the tyranny of gender as it *constrains* behavior in a spectrum of spaces and localities" (2010, p. 649, emphasis added). A pivotal special issue on "Trans Geographies" published in *Gender, Place & Culture* (Browne et al., 2010) points out that despite a few important exceptions (Namaste, 2000; Browne, 2004, 2005; Doan, 2007; Nash, 2007), geographical inquiry in general has assumed male/female and man/woman binaries, and has not fully engaged with queer and trans theorizing about gender diversity; neither has it addressed the lives and experiences of T/GNC people (Browne et al., 2010, p. 573). While the articles in this special issue contribute significantly to the field of trans geographies, few geography researchers have explored these issues further since its publication.

Other researchers have pointed to the importance of studying how T/GNC people change their behavior and avoid certain public places in response to transphobic harassment and/or violence (see Taylor, 2009; Scheim et al., 2013; Stotzer, 2014). Jody Herman's (2013) research surveyed 93 T/GNC people in Washington, DC about their experiences in gendered public restrooms, and found that 70 percent of survey respondents reported being denied access, and had been verbally harassed or physically assaulted in public restrooms (Herman, 2013). She argues that we have "built minority stressors for transgender and gender non-conforming people into our very environment due to our reliance on gender segregation in public facilities" (Herman, 2013, p. 67).

Clearly, gender segregation, place, and a fear of harassment and violence impact the health and well-being of T/GNC people. Through examining the relationship between trans people's avoidance of public spaces, transition status, and past experiences of violence, the Trans PULSE Project (Scheim et al., 2013) found that the majority of participants avoided using public washrooms for fear of transphobic harassment or violence. Among those who had begun or completed transition, 83 percent had avoided at least one space, compared to one-quarter of those who had not begun medical or social transition (Scheim et al., 2013). Bathroom avoidance has serious implications for physical health and emotional well-being, as it can lead T/GNC people to avoid a wide range of public spaces (such as schools, recreation facilities, stores, health care settings), simply because the bathrooms are unsafe (Scheim et al., 2013).

Emphasizing the important connection between health and place, the Aboriginal Two-Spirit and LGBTQ Migration, Mobility, and Health Research Project conducted in Winnipeg and Vancouver examined the impacts of moving on health and well-being as well as the use of, and recommendations

for, services for Aboriginal Two-Spirit and LGBTQ people (Ristock et al., 2010, 2011). In addition to social exclusion resulting from homophobia and transphobia (including from some Aboriginal communities and within housing programs), the participants in this study also described experiences of racism (when looking for housing, employment, and health services) as being among the negative impacts of moving (Ristock et al., 2010).

Although some participants from this project indicated that they had experienced suicidal feelings because of having little opportunity for housing or employment, many of those moving to Vancouver described positive outcomes, including increased well-being due to reduced social isolation, and opportunities to connect with other Two-Spirit people. Importantly, the study noted that "the resilience in the transgender community was enormous, not only did they physically change their living environments, they also changed their physical selves; some going on this journey without family support" (Ristock et al., 2011, p. 18). The research highlights the importance of a sense of community belonging and its connection to the health and well-being of Aboriginal Two-Spirit and LGBTQ people. In both Vancouver and Winnipeg, "participants moved in search of something and in order to create community and a feeling of belonging" (Ristock et al., 2010, p. 34). In sum, the researchers identified two key themes regarding how moving impacted the health and well-being of the participants:

1) moving in search of a "home" – described as being a "sense of belonging that can come with finding a safe, accepting community … rooted in relationships … that people have with each other and with geography"; and
2) disconnection – as a result of the impact of forced mobility through colonization, adoption or foster care, and/or residential schools which are also "connected to experiences of homophobia and transphobia in home communities and experiences of racism in LGBTQ communities" (2011, p. 19).

Mental Health and Well-being

The World Health Organization (WHO) (2014) defines mental health as:

> a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (n.p.)

It also stresses that:

> a climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health. (n.p.)

For T/GNC people, the social and spatial contexts of injustice, discrimination, and violence seriously erode mental health and well-being (Grant et al., 2011; Bauer et al., 2013).

Mental health issues emerging as a result of systemic oppression and marginalization, accumulated stigma, and discrimination can be referred to as "minority stress" (Meyer, 2003; Herman, 2013). Often, mental health issues arising from minority stress are misinterpreted by mental health service providers as resulting from an individual's gender identity or expression (McIntyre et al., 2011). Qualitative research conducted by the Trans PULSE Project found that trans participants reported

> a "double bind," in which health care providers were not able to see mental health issues as distinct from gender identity, and tended to either attribute mental health conditions to a client's gender identity or to attribute their gender identity to their mental health condition. (Rotondi et al., 2011b, p. 151)

McIntyre et al. (2011) note that, "the medical model typically neither accounts for nor responds to the impact of the social context of an individual's life and social determinants of health and well-being" (p. 182). Their research with mental health service providers in the Greater Toronto Area of Ontario found a tendency to rely on mental health practices and interventions governed by the medical model, which often results in mental health providers overlooking the social contexts of T/GNC people's lives (McIntyre et al., 2011).

T/GNC people experience poorer mental health outcomes compared with cisgender people, and this is directly related to experiences of discrimination associated with living in a transphobic and cisnormative environment (Bauer et al., 2013). Research has consistently shown that trans people experience high levels of depression, suicidal ideation, and suicide attempts (Scanlon et al., 2010; Rotondi et al., 2011a, 2011b; McNeil et al., 2012; Bauer et al., 2013; Heinz and MacFarlane, 2013; Scheim et al., 2013). Importantly, Bauer et al. (2013) in the Trans PULSE Project have pointed out that while most literature acknowledges these high levels of depression and suicide within trans communities, there has been limited examination of the relationship between experiences of trans-related social injustice and suicide. The findings from their research highlight a number of protective factors that have been shown to reduce depression, the risk of suicide for trans people, and improve their mental health. Some of these include:

- timely, accessible, and affordable transition-related health care;
- social and family support;
- strong parental support for T/GNC youth;
- having one's gender affirmed, in the case of trans women; and
- sexual satisfaction for trans men (Bauer et al., 2013).

Clear correlations exist between experiences of violence and various forms of mental health distress, including depression, post-traumatic stress disorder, increased anxiety, suicidal ideation, suicide attempts, and substance misuse (Stotzer, 2014). Recent studies in Canada and the USA have found extremely high rates of suicide for those who have experienced transphobic-related harassment, physical, and sexual assault (Scanlon et al., 2010; Bauer et al., 2013). The Trans PULSE Project found that "those who had experienced transphobic physical or sexual violence were seven times more likely to have attempted suicide in the past year" (Bauer et al., 2013, p. 42). The National Transgender Discrimination Survey in the USA found that visual nonconformers (44 percent), and those who are generally out about their transgender status (44 percent), were two groups at higher risk for attempted suicide (Grant et al., 2011).

Access to needed health and social services is another issue related to T/GNC peoples' mental health, particularly barriers in accessing substance use and addiction services, homeless shelters, transition houses, and sexual assault services, as well as mental health, harm reduction, and HIV intervention services (Lombardi and van Servellen, 2000; Namaste, 2000; White and Goldberg, 2006; Bauer et al., 2009; McNeil et al., 2012). In many cases, this has included an actual *denial* of health care, as well as a *refusal* to approve gender-affirming medical procedures (Namaste, 2000; McNeil et al., 2012; Rutherford et al., 2012). These barriers in accessing health and mental health support services have been discussed in recent literature, generally focusing on the relationship between access to transition-related health needs, mental health system gatekeeping, and T/GNC people's mental health; and a lack of trans-competent mental health service providers and discrimination in the delivery of services. Both of these themes are a result of systemic, institutional transphobia, and cisnormativity in health service contexts that contribute to the invisibility of T/GNC people and lack of provider knowledge (Bauer et al., 2009; McIntyre et al., 2011; Heinz and MacFarlane, 2013; Taylor, 2013).

Mental health service utilization rates in trans communities have not been widely documented in Canada. Some have suggested that this might be a result of the "complex relationship between medical service providers and trans individuals, who may be accessing mental health services for medical (transition-related) reasons rather than for mental health concerns" (McIntyre et al., 2011, p. 174). One Canadian study – the Vancouver Island Trans* Needs Assessment – documented whether respondents identified a need for mental health services, as well as their experiences with accessing mental health care (Heinz and MacFarlane, 2013). When asked to identify their personal top health care need, few prioritized mental health care access, instead citing general health care, social support, and public education and acceptance as the top needs (Heinz and MacFarlane, 2013, p. 4). Significantly, those who identified these top needs discussed specific priorities for quick, affordable access to surgeries within the province; local, speedy access to trans-specific medical expertise; and information about long-term hormone use (Heinz and MacFarlane, 2013). This finding is interesting, as other studies have documented the relationship between a lack of access to supportive gender affirming or transition-related health care, and depression and suicide – as well as the correlation between societal acceptance and social inclusion, social support, and mental health or well-being (Bauer et al., 2009; Rotondi et al., 2011a, 2011b; MacNeil et al., 2012; Bauer et al., 2013).

In their survey, the researchers with the Vancouver Island Trans* Needs Assessment distinguished between mental health care needed for reasons related to gender identity, and mental health care needed for other reasons. Most of the respondents (69 percent) indicated that they had accessed mental health care related to gender identity (Heinz and MacFarlane, 2013), and of these respondents, 49 percent said that they had to educate a mental health provider about trans issues. Some individuals explained that it was only because this is a requirement for access to gender-affirming surgeries or hormones. Only 24 percent of the respondents in this study indicated that they had mental health issues, but the majority (63 percent) reported having either considered (35 percent) or attempted (28 percent) suicide. So, while mental health care access was not prioritized as a top need, and the majority of respondents did not identify as living with mental health issues, their experiences of considering and attempting suicide reveal a more complex story about trans people's mental health and well-being. This finding suggests that the language or category of *mental health* and *mental health care* may not be meaningful or helpful for understanding the true lived experiences of emotional distress and well-being in trans communities, given their association with pathologizing psychiatric and biomedical discourses.

Significantly, 72 percent of respondents in the Trans* Needs Assessment study had to travel away from their home to obtain gender-affirming, trans-related care (primarily for surgical care), which included traveling to the mainland of British Columbia, other provinces in Canada, and other countries (Heinz and MacFarlane, 2013, p. 5). This lack of access to gender-affirming medical procedures is a significant part of the context of social injustice in the lives of T/GNC people in Canada – one which has significant harmful effects on psychological health and well-being (Bauer et al., 2013).

The dominant discourses within psychiatry and psychology continue to have a profoundly negative impact on T/GNC people's lives. They have pathologized gender diversity and constructed T/GNC people as "disordered" and "ill." Moreover, media discourses have perpetuated these stereotypes. This context presents a burden for T/GNC people and their loved ones, and affects our ability to speak openly about the mental health and well-being of T/GNC people. In addition, within the academic health literature there has been minimal research and writing about trans resiliency, and few studies to date have examined what factors promote resilience (Testa et al., 2014). In response to these harmful dominant framings of trans people as "miserable and full of rejection, depression and despair,"

in 2008 and 2009 a volunteer group of trans people and allies in Vancouver decided to organize two community events for T/GNC people "based on the radical concept that trans people can be happy" (Neo Eamas and MacFarlane, 2014, p. 137). As Tien Neo Eamas and Devon MacFarlane (2014) describe, the organizers sought to "inspire others to find ways to promote the revolutionary idea of celebrating trans people" (137) and promote trans happiness, through organizing a "Happy Tranny Day" in 2008 and "Gender Euphoria Day" in 2009. These kinds of creative, grassroots community strategies are rarely included in discussions about community mental health interventions, yet it is critically important to make them visible and highlight the way that socially marginalized groups creatively address health, well-being, and resiliency outside of professionalized and institutionalized mental health services.

Frameworks: Intersectionality and Critical Trans Politics

An approach informed by intersectional, critical trans, and anti-colonial theories challenges us to think critically about what counts as a health issue or form of violence, and how cisnormative and colonial gender norms limit our imaginations, research strategies, and health prevention and intervention initiatives. These approaches also challenge de-raced and de-classed understandings of social exclusion and inclusion, belonging, health, well-being, and safety in the lives of T/GNC people. We can apply intersectional theory (see Chapter 2) to examine the way that interlocking oppressions may interact to increase health inequities or vulnerabilities to illness or violence. We can draw on intersectional theorizing, critical trans, and anti-colonial theorizing to look more in-depth at how these health inequities are socially and spatially produced, how they are interlocking, how we are connected to these systems, and what can be done to change them.

From the previous discussion of the existing literature, we can begin to see that to understand the connections between violence, mental health, and place in the lives of T/GNC people, and how these conditions of marginalization are produced, scholars and activists need to take up an interdisciplinary approach that acknowledges various social determinants of health in trans communities. Here, intersectionality, informed by critical trans and anti-colonial theories, supports us to resist universalist models of identity and "one-size-fits-all" approaches to health promotion, anti-violence organizing, health and trauma support service provision, and research. It moves away from additive approaches, and helps us to see how the conditions and spaces of violence and marginalization are produced simultaneously.

Critical trans politics call for an intersectional framework that places the lived experiences of poor, working-class, trans people of color and Indigenous people at the center of theorizing and organizing (particularly racialized poor trans women) (Namaste, 2000; Spade, 2011; Johnson, 2013). Trans legal scholar Dean Spade (2011) has called for a critical trans approach

that draws from the insights of critical race feminist and intersectional theories, but extends beyond by centering on resistance to systems that are most harmful to trans people. This "raises demands like an end to wealth and poverty, an end to immigration enforcement, and the abolition of all forms of imprisonment (immigration, criminal punishment, medical, and psychiatric)" (Nicols, 2012, n.p.). Spade suggests that a critical trans politics offers social justice movements "a particular frame for understanding how processes of gendered racialization are congealed in violent institutions" (Nicols, 2012, n.p.). Such approaches and frameworks would generate valuable knowledge regarding the injustices experienced by T/GNC individuals, as well as on the complex interconnections between violence, place, and mental health among this diverse community.

Directions for Health Geographers

The contexts of erasure and harmful research about T/GNC and Two-Spirit people conducted by cisgender researchers clearly indicate that future research by health geographers must begin with a critical examination of cisnormativity as a social determinant of health, and one that is produced simultaneously with other systems of oppression. It is important for health geographers to understand that cisnormativity, and the societal enforcement of gender norms and related violence, impacts the health of *all* Canadians, not only T/GNC Canadians. Most research published in health geography (and geography more broadly) assumes a gender and sex binary, and cisgender identity as the most natural and normal. Health geographers must acknowledge gender diversity, and resist these problematic cisnormative assumptions as part of a wider commitment to investigating the sociospatial conditions that produce health inequities in Canada.

Drawing on the work by Namaste (2000), Trans PULSE (Bauer et al., 2009), and Hunt (2015), researchers can take up the concept of erasure as a framework for understanding the systematic nature of trans marginalization. The past and present context of harmful research with T/GNC communities, and negative experiences with health care providers, highlight the importance of collaborative, community-based participatory research that is controlled by T/GNC communities. Community-engaged and controlled research methodologies are well suited for marginalized populations whom historically have been left out of research processes, or whom have experienced discrimination or barriers to health care access.

Research is needed that examines the intersections between different forms of social marginalization, violence, place, and health in the lives of different T/GNC people. All T/GNC people are not at the same risk for violence, neither do they all experience violence in the same way, in the same places. It is important to acknowledge these differences: for example, the high rates of violence experienced by racialized T/GNC people living in poverty, who are working class and/or sex workers (especially trans women). More research is

urgently needed that explicitly centers on the interlocking contexts of racism, poverty, and transphobia in particular places, and their impact on mental health and well-being. Such research also must employ community-engaged and collaborative research approaches which highlight sociospatial factors that promote resiliency and safety. Research is also needed that draws on T/GNC community knowledge to develop best practices for trauma-informed health care (including mental health care), by drawing on insights from intersectional, critical trans, and anti-colonial theories.

Drawing on previous work in health geography, researchers can look at the relationship between minority stress and place in the lives of T/GNC people, or what has been called "place-based minority stress" (Lewis, 2014). Recent research has suggested that minority stress may be informed by various geographical factors (Lewis, 2014). Researchers can examine the impact of this stress across the life course for T/GNC people, and the ways that such stress shapes mental health and well-being, social inclusion, and resilience. Similarly, recent work on gay, lesbian, queer and Two-Spirit people's mobility and migration in the fields of geography and health studies may be useful in providing insights for future research in trans health geography, and in health geography more broadly.

Health geographers in Canada must acknowledge colonialism as a social determinant of health that is spatially produced, and examine the way that colonial and cisnormative gender norms are enforced through colonial practices (Scheim et al., 2013; Hunt, 2015). Research discussed earlier from the Aboriginal Two-Spirit and LGBTQ Migration, Mobility, and Health Research Project highlights the combined health effects of historical trauma, colonialism, and anti-Aboriginal racism on Two-Spirit/Aboriginal trans and gender diverse people, as well as the importance of a sense of community belonging for Two-Spirit people. Research is needed that explores in-depth, how and where Aboriginal T/GNC and Two-Spirit people experience belonging, the impact on their mental health and well-being, as well as how forms of social exclusion and marginalization such as racism, classism, and ableism operate *within* T/GNC communities to create barriers to inclusion and a sense of belonging.

Health geography researchers need to be aware of the negative impact of cisnormative and transphobic psychiatric and mental health discourses on T/GNC people, and how this context influences what language is meaningful (or not) when talking about emotional and psychological well-being. For example, "mental health" may not be a term that resonates for T/GNC people. Researchers also need to be aware of the critiques of psychiatric frameworks for understanding psychological distress, and to explore new language and ways of conceptualizing psychological or emotional distress or well-being. Similarly, researchers need to unpack and critically examine the assumptions surrounding the language of "violence" (including intimate partner violence, domestic violence, hate-motivated violence) and "place," and examine the exclusions produced through cisnormativity. Researchers can draw on existing work in mental health geography to explore how different contexts and places undermine or enhance safety, belonging, resiliency, mental health, and well-being for T/GNC people. It would be useful to examine the mental and physical health impacts of transphobic policies and the relationship to place: for example, being forced to travel or move as a result of transphobic institutionalized policies and laws. This also could extend work in the area of geography of health care access in rural and urban spaces.

Future research is needed also to examine the relationship between place and belonging by drawing on findings from previous studies that have indicated that for some T/GNC people, a "connection with a trans community may be a determinant of resilience" (Testa et al., 2014, p. 33). T/GNC communities have stressed the importance of highlighting and studying individual and collective resilience and strength, not only experiences of marginalization, violence, emotional distress, or mental health challenges. It is important to take direction from T/GNC communities, and to not assume that studies on resilience in other communities will necessarily translate to T/GNC communities. Despite a historical and ongoing lack of Canadian and trans-positive research, important new research is being conducted or led by trans communities. Trans activism and organizing in Canada continues to drive important new research, inform policy decisions, advance new understandings about violence, health, and place, while setting out new directions for best practice for trans-affirming health services. Importantly, this work on resilience also needs to acknowledge the diversity and inequalities that exist *within* this community, and the ways that race, class, ability, age, sexual orientation, and gender complexly intersect to shape the everyday lives of T/GNC people.

References

American Psychiatric Association, 2013. Gender dysphoria. Available online at http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf (accessed October 3, 2014).

Bauer, G.R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. and Boyce, M., 2009. "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care*, 20(5), pp. 348–61.

Bauer, G.R., Boyce, M., Coleman, T., Kaay, M., Scanlon K. and Travers, T., 2010. Who are trans people in Ontario? *Trans PULSE E-Bulletin*, 1(1). Available online at http://transpulseproject.ca/wp-content/uploads/2010/07/E1English.pdf (accessed October 3, 2014).

Bauer, G.R., Travers, R. Scanlon, K. and Coleman, T.A., 2012. High heterogeneity of HIV-related sexual risk among transgender people in Ontario, Canada: A province-wide respondent-driven sampling survey. *BMC Public Health*, 12. Available online at www.biomedcentral.com/1471-2458/12/292 (accessed October 3, 2014).

Bauer, G.R., Pyne, J., Francino, M.C. and Hammond, R., 2013. Suicidality among trans people in Ontario: Implications for social work and social justice. *Service Social*, 59(1), pp. 35–62.

Brown, N., 2011. Holding tensions of victimization and perpetration: Partner abuse in trans communities. In: J. Ristock, ed. *Intimate partner violence in LGBTQ lives*. New York: Routledge. pp. 153–68.

Brown, N.R., 2007. Stories from outside the frame: Intimate partner abuse in sexual-minority women's relationships with transsexual men. *Feminism & Psychology*, 17(3), pp. 373–93.

Browne, K., 2004. Genderism and the bathroom problem: (Re)materializing sexed sites, (re)creating sexed bodies. *Gender, Place & Culture*, 11(3), pp. 331–46.

Browne, K., 2005. Stages and streets: Reading and misreading female masculinities. In: B. Van Hoven and K. Horschelmann, eds. *Spaces of masculinities*. London: Routledge, pp. 237–48.

Browne, K., Nash, C.J. and Hines, S., 2010. Introduction: Towards trans geographies. *Gender, Place & Culture*, 17(5), pp. 573–77.

Cermele, J., Daniels, S. and Anderson K., 2001. Defining normal: Constructions of race and gender in the DSM-IV casebook. *Feminism & Psychology*, 11(2), pp. 229–47.

Coleman, T., Bauer, G., Scanlon, K., Travers, R., Kaay, M. and Francino, M., 2011. Challenging the binary: Gender characteristics of trans Ontarians. *Trans PULSE E-Bulletin*, 2(2), pp/. 1–3. Available online at http://transpulseproject.ca/wp-content/uploads/2011/12/E4English.pdf (accessed February 3, 2016).

Courvant, D. and Cook-Daniels, L., 1998. *Trans and intersex survivors of domestic violence: Defining terms, barriers & responsibilities*. Portland, OR: Survivor Project. Available online at www.survivorproject.org/defbarresp.html (accessed October 3, 2014).

Curtis, S., 2010. *Space, place, and mental health*. Farnham: Ashgate.

Daley, A. and Mulé, N.J., 2014. LGBTQs and the DSM-5: A critical queer response. *Journal of Homosexuality*, 61(9), pp. 1288–312.

Doan, P.L., 2007. Queers in the American city: Transgendered perceptions of urban space. *Gender, Place & Culture*, 14(1), pp. 57–74.

Doan, P.L., 2010. The tyranny of gendered spaces: Reflections from beyond the gender dichotomy. *Gender, Place & Culture*, 17(5), pp. 635–54.

FORGE (For Ourselves: Reworking Gender Expression), 2012a. Who are transgender people? Victim service providers' fact sheet #1. Available online at http://forge-forward.org/wp-content/docs/FAQ-05-2012-trans101.pdf (accessed October 3, 2014).

FORGE (For Ourselves: Reworking Gender Expression), 2012b. Transgender rates of violence. Victim service providers' fact sheet #6. Available online at http://forge-forward.org/wp-content/docs/FAQ-10-2012-rates-of-violence.pdf (accessed February 3, 2016).

Goldberg, J.M. and White, C., 2011. Reflections on approaches to trans anti-violence education. In: J. Ristock, ed. *Intimate partner violence in LGBTQ lives*. New York: Routledge, pp. 56–77.

Grant, J., Mottet, L., Tanis, J., Harrison, J., Herman, J. and Keisling, M., 2011. *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Greenberg, K., 2012. Still hidden in the closet: Trans women and domestic violence. *Berkeley Journey of Gender, Law & Justice*, 27(3), pp. 198–251.

Heinz, M. and MacFarlane, D., 2013. Island lives: A trans community needs assessment for Vancouver Island. *SAGE Open*, 3(3), pp. 1–13.

Herman, J.L., 2013. Gendered restrooms and minority stress: The public regulation of gender and its impact on transgender people's lives. *Journal of Public Management & Social Policy*, 19(1), pp. 65–80.

Hunt, S., 2015. The embodiment of self-determination: Beyond the gender binary. In: M. Greenwood, C. Reading and S. de Leeuw, eds. *Determinants of Indigenous peoples' health in Canada*. Canadian Scholars' Press, pp. 104–19.

Johnson, J., 2013. Cisgender privilege, intersectionality, and the criminalization of CeCe McDonald: Why intercultural communication needs transgender studies. *Journal of International and Intercultural Communication*, 6(2), pp. 135–44.

LeFrancoise, B.A., Menzies, R. and Reaume, G., 2013. *Mad matters: A critical reader in Canadian mad studies*. Toronto: Canadian Scholars' Press Inc.

Lewis, N., 2014. Rupture, resilience, and risk: Relationships between mental health and migration among gay-identified men in North America. *Health and Place*, 27, pp. 212–19.

Longman Marcellin R., Scheim A., Bauer G. and Redman N., 2013a. Experiences of racism among trans people in Ontario. *Trans PULSE E-Bulletin*, 3(1), pp. 1–2. Available online at http://transpulseproject.ca/research/experiences-of-racism-among-trans-people-in-ontario/ (accessed October 3, 2014).

Longman Marcellin R., Bauer, G.R. and Scheim, A.I., 2013b. Intersecting impacts of transphobia and racism on HIV risk among trans persons of colour in Ontario, Canada. *Ethnicity and Inequalities in Health and Social Care*, 6(4), pp. 97–107.

Lombardi, E. and van Servellen, G., 2000. Building culturally sensitive substance use prevention and treatment programs for transgendered populations. *Journal of Substance Abuse Treatment*, 19(3), pp. 291–6.

McIntyre, J., Daley, A., Rutherford, K. and Ross, L., 2011. Systems-level barriers in accessing supportive mental health services for sexual and gender minorities: Insights from the provider's perspective. *Canadian Journal of Community Mental Health*, 30(2), pp. 173–86.

McNeil, J., Bailey, L., Ellis, S., Morton, J. and Regan, M., 2012. *Trans mental health study* 2012. Edinburgh: Equality Network. Available online at www.scottishtrans.org/Uploads/Resources/trans_mh_study.pdf (accessed October 3, 2014).

Meyer, I.H., 2003. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), pp. 674–97.

Moran, L. and Sharpe, A., 2004. Violence, identity and policing: The case of violence against transgender people. *Criminology and Criminal Justice*, 4(4), pp. 395–417.

Mulé, N., Daley, A. and The Rainbow Health Network, 2010. Queer lens of resistance: A critical anti-oppressive response to the DSM-V. In: Ontario Studies in Education (OISE), *PsychOut: A Conference for Organizing Resistance Against Psychiatry*. Toronto: OISE. Available online at http://individual.utoronto.ca/psychout/papers/mule-etal_paper.pdf (accessed October 3, 2014).

Munson, M. and Cook-Daniels, L., 2015. Transgender sexual violence survivors: A self-help guide to healing and understanding. FORGE Transgender Sexual Violence Project. Available online at http://forge-forward.org/wp-content/docs/self-help-guide-to-healing-2015-FINAL.pdf (accessed February 2, 2016).

Namaste, K., 1996. Genderbashing: Sexuality, gender, and the regulation of public spaces. *Environment and Planning D*, 14, pp. 221–40.

Namaste, V.K., 2000. *Invisible lives: The erasure of transsexual and transgender people*. Chicago, IL: University of Chicago Press.

Nash, C., 2007. Material entanglements: Queer geographies and trans experience and embodiment. Paper presented at the Association of American Geographers, Washington, DC, April.

Nash, C., 2010. Trans geographies, embodiment and experience. *Gender, Place & Culture*, 17(5), pp. 579–95.

National Coalition of Anti-Violence Programs, 2014. *Lesbian, gay, bisexual, transgender, queer and HIV-affected hate violence 2013*. New York: National Coalition of Anti-Violence Programs.

Neo Eamas, T. and MacFarlane, D., 2014. Happy Tranny Day. In: D. Irving, and R. Raj, eds. *Trans activism in Canada: A reader*. Toronto: Canadian Scholars' Press, pp. 137–46.

Nicols, R., 2012. Toward a critical trans politics: An interview with Dean Spade. *Upping the Anti*, 14. Available online at http://uppingtheanti.org/journal/article/14-dean-spade/ (accessed November 28, 2014).

National Film Board of Canada, 2014. Educator's guide for *My Prairie Home. A documentary-musical featuring Rae Spoon: A film by Chelsea McMullan*. Available online at www3.nfb.ca/sg/100749.pdf (accessed October 3, 2014).

Pyne, J., 2014. The governing of gender non-conforming children: A dangerous enclosure. *Annual Review of Critical Psychology*, 11, pp. 79–96.

Ristock, J., ed. 2011. *Intimate partner violence in LGBTQ lives*. New York: Routledge.

Ristock, J., Zoccole, A. and Passante, L., 2010. Aboriginal Two-Spirit and LGBTQ Migration, Mobility, and Health Research Project: Winnipeg final report. Available online at www.2spirits.com/PDFolder/MMHReport.pdf (accessed October 3, 2014).

Ristock, J., ed. 2011. *Intimate partner violence in LGBTQ lives*. New York: Routledge.

Ristock, J., Zoccole, A. and Potskin, J., 2011. Aboriginal Two-Spirit and LGBTQ Migration, Mobility, and Health Research Project: Vancouver, final report. Available online at www.2spirits.com/PDFolder/2011%20Vancouver%20full%20report%20final.pdf (accessed October 3, 2014).

Rotondi, N.K., Bauer G., Travers R., Travers A., Scanlon K. and Kaay M., 2011a. Depression in male-to-female transgender Ontarians: Results from the Trans PULSE Project. *Canadian Journal of Community Mental Health*, 30(2), pp. 113–33.

Rotondi, N.K., Bauer, G., Scanlon, K., Kaay, M., Travers, R. and Travers, A., 2011b. Prevalence of and risk and protective factors for depression in female-to-male transgender Ontarians: Trans PULSE Project. *Canadian Journal of Community Mental Health*, 30(2), pp. 135–55.

Rutherford, K., MacIntyre, J., Daley, A. and Ross, L.E., 2012. Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education*, 46(9), pp. 903–13.

Scanlon, K., Travers, R., Coleman, T., Bauer, G. and Boyce, M., 2010. Ontario's Trans communities and suicide: Transphobia is bad for our health. *Trans PULSE E-Bulletin*, 1(2). Available online at http://transpulseproject.ca/research/ontarios-trans-communities-and-suicide/ (accessed October 3, 2014).

Scheim, A.I, Jackson, R., James, L., Dopler, T.S., Pyne, J. and Bauer, G.R., 2013. Barriers to well-being for Aboriginal gender-diverse people: Results from the Trans PULSE Project in Ontario, Canada. *Ethnicity and Inequalities in Health and Social Care*, 6(4), pp. 108–20.

Scheim, A.I., Bauer, G.R., Pyne, J., 2014. Avoidance of public spaces by trans Ontarians: The impact of transphobia on daily life. *Trans PULSE E-Bulletin*, 4(1). Available online at http://transpulseproject.ca/research/avoidance-of-public-spaces-by-trans-ontarians-the-impact-of-transphobia-on-daily-life/ (accessed October 3, 2014).

Serano, J., 2007. *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Emeryville, CA: Seal Press.

Stotzer, R. L., 2009. Violence against transgender people: A review of United States data. *Aggression and Violent Behavior*, 14, pp. 170–9.

Stotzer, R. L., 2014. Bias crimes based on sexual orientation and gender identity: Global prevalence, impacts and causes. In: D. Peterson and V. R. Panfil, eds. *Handbook of LGBT Communities, Crime, and Justice*. New York: Springer, pp. 45–64.

Spade, D., 2011. *Normal life: Administrative violence, critical trans politics and the limits of law*. New York: South End Press.

Taylor, C., 2009. Health and safety issues for Aboriginal transgender/Two-Spirit people in Manitoba. *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research*, 2, pp. 63–84. Available online at www.caan.ca/wp-content/uploads/2012/05/Health-and-Safety-Issues-for-Aboriginal-TransgenderTwo-Spirit-People-in-Manitoba.pdf (accessed October 3, 2014).

Taylor, C., and Ristock, J.L. 2011. "We are all treaty people": An anti-oppressive research ethics of solidarity with Indigenous LGBTQ people living with partner violence. In: J.L. Ristock, ed. *Intimate partner violence in LGBTQ lives*. New York: Routledge, pp. 301–19.

Taylor, E., 2013. Trans men's health care experiences: Ethical social work practice beyond the binary. *Journal of Gay & Lesbian Social Services*, 25(1), pp. 102–20.

Testa, R., Jimenez, C., and Rankin, S. 2014. Risk and resilience during transgender identity development: The effects of awareness and engagement with other transgender people on affect. *Journal of Gay and Lesbian Mental Health*, 18(1), pp. 31–46.

Travers, R., Pyne, J., Bauer, G., Munro, L., Giambrone, B., Hammond, R., and Scanlon, K., 2013. "Community control" in CBPR: Challenges experienced and questions raised from the Trans PULSE project. *Action Research*, 11(4), pp. 403–22.

Turner, L., Whittle, S. and Combs, R., 2009. *Transphobic hate crime in the European Union: Press for change*. Available online at http://transgenderinfo.be/wp-content/uploads/transphobic_hate_crime_in_eu.pdf (accessed February 3, 2016).

White, C. and Goldberg, J.M., 2006. Expanding our understanding of gendered violence: Violence against trans people and their loved ones. *Canadian Women's Studies Journal*, 25(1–2), pp. 124–8.

World Health Organization (WHO), 2014. Mental health: Strengthening our response. Factsheet no. 220. Available online at www.who.int/mediacentre/factsheets/fs220/en (accessed October 3, 2014).

World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, The World Bank, 2013. *Implementing comprehensive HIV/STI programmes with sex workers: Practical approaches from collaborative interventions*. Geneva: World Health Organization. Available online at www.who.int/hiv/pub/sti/sex_worker_implementation/en/ (accessed October 3, 2014).